



**Accident Fund**  
 INSURANCE COMPANY OF AMERICA  
 232 S. Capitol Avenue  
 P.O. Box 40790  
 Lansing, MI 48901-7990

**Application for Exclusion from Coverage  
 Officers and Stockholders**

Name of Corporation \_\_\_\_\_

City \_\_\_\_\_ Policy Number \_\_\_\_\_

I (we), officer(s) and stockholder(s) of a corporation which has not more than ten (10) stockholders and each individually own at least 10% of the stock of the corporation as approved by the corporation board of directors to elect to be excluded from the coverage afforded by the Michigan Workers' Disability Compensation Act. This is to apply to the present, as well as any succeeding policies.

I (we), the undersigned, agree to hold the Accident Fund harmless from and against all loss and expense because of injury or death sustained in my (our) employment.

Full Name (please print)	Signature	Corporate Title	% of stock ownership
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20.

The \_\_\_\_\_ Corporation hereby consents to the exclusion of the above named individual(s) from coverage under our workers' compensation insurance policy.

By \_\_\_\_\_

To be signed by elected corporate secretary.  
 If no secretary then the president should sign.

This signed form may be returned by fax. Please fax to your Underwriting Consultant.